VZV Specimen Collection Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

UNIQUE IDENTIFIER (ASSIGNED BY CDC) _____

PATIENT INFORMATION

Name (Last, First): _____

Date of Birth: ____/____/____

Sex: ☐ Male ☐ Female

Address: _____

City/State/Zip: _____

Phone: _____ _____

PROVIDER INFORMATION

Name: _____

Institution: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

E-mail: _____

SPECIMEN INFORMATION

Date Collected: ____/____/____

Source of Specimen:

☐ Skin Lesion:
- ☐ Vesicle (fluid-filled blister)
- ☐ Papule (bump)
- ☐ Macule (flat lesion)
- ☐ Crust/Scab

☐ Blood
☐ Cerebrospinal Fluid
☐ Other *(specify)*: _____

Reason for Specimen Submission:

- ☐ Suspected transmission of vaccine virus
- ☐ Suspected vaccine adverse event
- ☐ Suspected vaccine failure
- ☐ Lab confirmation
- ☐ Determine patient's susceptibility
- ☐ Strain identification (wild type vs. vaccine strain)
- ☐ Other *(specify)*: _____

If an **adverse event** is suspected, has a VAERS report been submitted? ☐ Yes – VAERS number: _____ ☐ No

CLINICAL HISTORY

Date of Rash Onset: ____/____/____

Rash Type:

- ☐ Macules (flat) Approximate Number: _____
- ☐ Papules (raised) Approximate Number: _____
- ☐ Vesicles (fluid) Approximate Number: _____

Diagnosis:

☐ Varicella (Chickenpox) ☐ Zoster (Shingles)
☐ Other *(specify)*: _____

Previous Chickenpox:

Has the patient ever had **chickenpox** before this illness/rash?
☐ Yes ☐ No ☐ Unknown
If yes, at what age? _____

VACCINE INFORMATION

Has the patient received the varicella vaccine?
☐ Yes ☐ No ☐ Unknown

Dose 1: Date ____/____/____ Lot Number _____

Dose 2: Date ____/____/____ Lot Number _____

Medications:

Did the patient take **steroid**(s) or **immunosuppressant**(s) during the month prior to rash onset? ☐ Yes ☐ No

If yes, check all that apply and specify **name**, **dose**, and **route** of administration for each medication:

☐ Steroid(s) *(specify)*: _____

☐ Immunosupressant(s) *(specify)*: _____

☐ Other(s) *(specify)*: _____

In the week before the specimen was collected, did the patient take **oral acyclovir**, **famciclovir**, or **valacyclovir**?
☐ Yes ☐ No ☐ Unknown

If yes, specify: _____

Additional Clinical Information: _____

MAIL FORM AND SPECIMEN TO:

CDC • National VZV Laboratory
1600 Clifton Road, NE • MS G-18
Atlanta, GA 30333
Tel: 404-639-3667 • Fax: 404-639-4056 • E-mail: vzvlab@cdc.gov